Electronic Data Interchange (EDI) Supervisor Training Module

Department of Defense
Civilian Personnel Management Services
Injury Compensation and Unemployment Compensation

Revised August 23.2002

What is Electronic Data Intercha

Electronic Data Interchange (EDI) is a process that allows Federal Agencies to electronically submit completed CA-1 or CA-2 initial claim forms to the Office of Workers' Compensation Programs.

The Civilian Personnel Management Service, Injury and Unemployment Compensation Division (CPMS-ICUC) has partnered with the Office of Workers' Compensation Program (OWCP) to develop a process that allows each component to submit initial claim forms electronically through the EDI Tracking System.

The EDI Tracking System allows employees and supervisors to complete the initial claim forms on the internet, electronically submit the claim form to the servicing Injury Compensation Program Administrator for authentication, and transmit the information to OWCP National Headquarters for processing by each OWCP District Office.

Scope

This training module is intended to:

- Provide the supervisor with an understanding of the EDI process.
- Teach the supervisor how to complete an on-line claim form, such as a CA-1 or CA-2
- Guide the supervisor in the process of printing, and submitting the claim form to the appropriate Injury Compensation Program Administrator (ICPA) for review and authentication.

NOTE: This training module is not intended to provide the supervisor with a detailed understanding of the Federal Employees' Compensation Act (FECA) as administered by the Office of Workers' Compensation Programs (OWCP). This training also, is not intended to provide the supervisor with a detailed understanding of the supervisor role within the injury compensation program. To request training in these subject areas, please click here.

Objectives

Upon completion of this module the supervisor will be able to:

- understand the EDI Tracking System basics.
- identify the benefits of the electronic process.
- verify that your workstation meets the standard system requirements.
- navigate through the application using special keys and functions.
- maintain the security of data.
- access and understand the data within the Supervisor View of EDI.
- complete the on-line initiating claim form with an employee.
- print the paper-document for signatures and filing.
- submit an initiating claim form to the appropriate ICPA.

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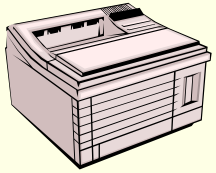
Electronic Data Interchange Tracking System (EDI) Supervisor Training Module

Process Flow

BEGIN

Employee Reports the injury to his/her supervisor

Supervisor and Employee complete the On-Line initiating claim form



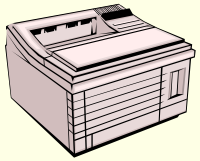
Supervisor prints completed form

Injured employee signs the printed copy of the initiating claim form

Supervisor electronically submits claim for processing

The responsible ICPA office is notified that a claim is awaiting authentication

ICPA reviews claim for accuracy, enters appropriate codes, corrects any errors and authenticates or rejects the claim



ICPA Prints claim. If Non-reportable, claim is REJECTED and form is placed in the OMF

Claim is batched for transmittal to OWCP

OWCP receives claim, validates data, and submits data to District OWCP for case number assignment

Claim Number is received at National OWCP and transmitted back to ICUC

Certain Claim data is then loaded into the DIUCS2000 system for case review.

END

Benefits of Electronic Claim Sub

On-line completion of claim by employee and supervisor

- ✓ Expedites processing of workers' compensation claims
- ✓ Reduces lag-time from supervisor to ICPA for authentication
- ✓ Improves communication between employee and supervisor
- ✓ Provides more comprehensive data for internal claims systems

On-Line ICPA authentication provides efficient review of claim

- ✓ Generates immediate request for authentication to ICPA
- ✓ Establishes standard validation of data to conform with OWCP transmittal acceptance
- ✓ Isolates case as ready for transmittal once ICPA authenticates the claim
- ✓ Provides for daily transmittal to the OWCP

Electronic transmittal of claim data to OWCP reduces time-lag

- ✓ Assists DoD in meeting statutory requirements for timely filing of claims
- ✓ Reduces OWCP claim number assignment time to less than 48 hours
- ✓ Allows for prompt medical service authorizations and bill payments
- ✓ Virtually eliminates data entry errors of claim information
- ✓ Increases level of service to claimants

Record Keeping

The electronic version of the initiating claim form becomes the official record of the injury once it is transmitted to the OWCP.

Supervisor Record Keeping

- Supervisors are required to print a copy of the completed claim form prior to submitting the claim to an ICPA for authentication and processing with the OWCP. This form must be signed by the employee and the supervisor. A copy may be made for the employee, including the receipt of notice, however, the form with original signatures must be kept in the employees medical folder.

ICPA Record Keeping

- When the ICPA makes any changes to the employee or supervisor portions of the claim form, the ICPA must initial such changes and notify the supervisor and employee.

Workstation Requirements

Any workstation used to access the EDI Tracking System must meet or exceed certain system requirements.

Your local ISD personnel may assist you in determining if your workstation meets or exceeds the following system requirements:

- Windows 95, Windows 98, NT 4.0 or Windows2000 operating system
- Pentium 90 MHz processor (or higher)
- 12 MB free hard disk space (recommended 20 MB)
- 16 MB system RAM (recommended 24 MB)
- Local Area Network connection or dial-up modem
- Proxy Server must be set to Port 9000
- Web browser with 128 bit encryption
- Internet Explorer 5.0 or later (Free Download)
- Adobe Acrobat Reader 5.0 or later (Free Download)

Note: The EDI Tracking System performs best using direct LAN or other Ethernet-based connections, however, the application will also function properly over dial-up modem (28.8kbps or better).

Special Keys and Functions

Color Coded Screens

Each field is color-coded to visually assist you with completing the on-line claim form.

- **WHITE** data fields represent mandatory fields requiring user entry
- **YELLOW** data fields represent optional fields, and may be completed if appropriate
- **GREY** data fields represent display-only fields that cannot be altered.

CNTL+ Keys

EDI Tracking System utilizes combination function keys. When pressed at the same time, the combination function keys provide the user with information that is helpful in completing, and authenticating the initiating claim forms.

- **CNTL + L** – provides a listing of values and descriptions that correlate with the specific data field that your cursor is placed in. This function will display a separate dialog box only when data is available to select from.

System Security

The EDI Tracking System contains sensitive-restricted data such as social security number and work-related medical diagnosis' that is protected by the Privacy Act of 1974. Security features are an integral part of limiting the availability of this data to only those persons with a valid 'need to know'.

To protect this data, three separate and distinct views have been designed to limit data access within the EDI Tracking System.

Supervisor View

This view does not require the user to have a secure Logon ID and Password, as the data is not added to the database until after the supervisor submits the claim electronically.

ICPA Authentication View

This view requires the user to have a secure Logon ID and Password. The user's agency must also be enrolled in EDI with an alias e-mail address. To obtain a Logon ID and Password, the ICPA must complete the Systems Access Request Form.

ICPA Re-Route View

The Logon ID and Password established for the ICPA Authentication View is also used for this view. However, the ICPA must log into a different Internet Address (URL) to access this view.

EDI TRACKING SYSTEM

SCREEN REVIEW

SUPERVISOR VIEW

Supervisor View

This view allows the supervisor and employee to complete the initiating claim form without accessing the database. Once the claim form is submitted, the application then populates the database with the information captured by the application. The supervisor may access the initiating claim forms by entering the following URL into the web browser:

https://isdmid1.cpms.osd.mil/web_html/static_java_edi_sup.html

Once the website is accessed, the supervisor will be requested to enter the injured employee's social security number, and date of birth to begin the claim process. The supervisor must also click on the appropriate radio button to indicate that the claim form being filed is either:

- **CA-1** Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation
- **CA-2** Federal Employee's Notice of Occupational Disease or Illness and Claim for Compensation

EDI Formats

The EDI screens depict the initiating claim form format of the hard copy forms CA-1 and CA-2. Therefore, the basic instructions for completing the forms are the same as with paper.

A copy of these instructions can be obtained on-line at:

http://www.dol.gov/esa/regs/compliance/owcp/forms.htm

The EDI process requires that some additional information must be provided to the OWCP that is not required in the manual process. Therefore, the electronic format includes those data fields within the application.

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Place your cursor over each asterisk (*) to get information about what is required of the user, and the processes that the system will initiate based upon your entry.

EDI_INITIAL_SUP

Enter A New U.S. Department of Labor Worker's Compensation Claim Form:

Claimant

Social Security Number (SSN): 111111111

Date of Birth (MM/DD/YYYY): 08011966

Claim Form Type

- (•) CA-1 Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay / Compensation
- ( ) CA-2 Notice of Occupational Disease and Claim for Compensation

Enter Claim **Exit**

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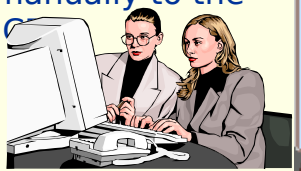
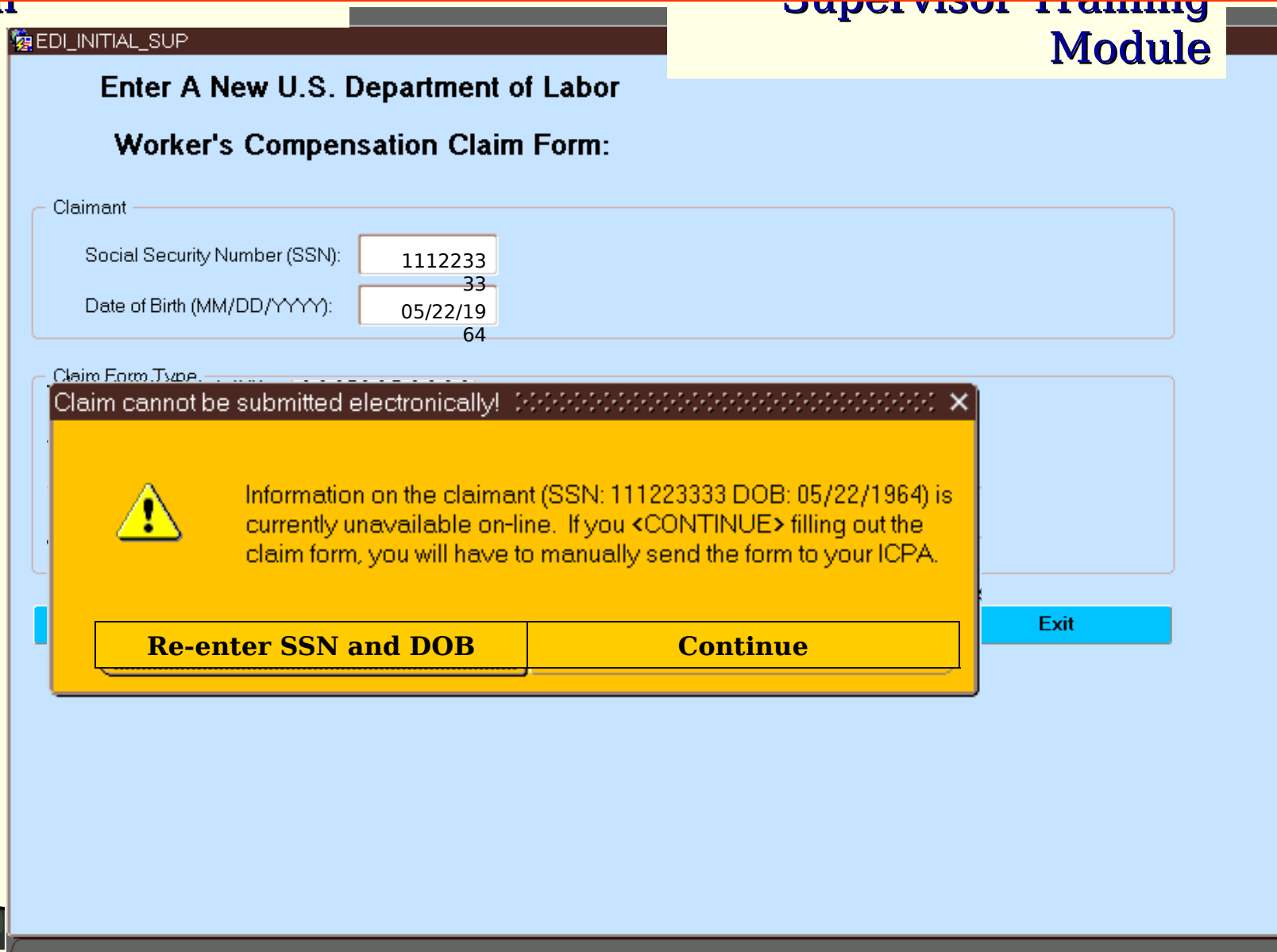
When the system cannot find a match of the claimant's SSN and Date of Birth, this dialog box will appear to notify you that the claim must be submitted manually to the ICPA completing the form on behalf of the employee and do not know either the claimant's SSN or Date of Birth, you may enter 111223333 as a placeholder. In this case, the form, must also be printed and submitted manually to the IC




EDI_INITIAL_SUP
Enter A New U.S. Department of Labor
Worker's Compensation Claim Form:
Claimant
Social Security Number (SSN):
1112233 33
Date of Birth (MM/DD/YYYY):
05/22/19 64
Claim Form Type
Claim cannot be submitted electronically!
Information on the claimant (SSN: 111223333 DOB: 05/22/1964) is currently unavailable on-line. If you <CONTINUE> filling out the claim form, you will have to manually send the form to your ICPA.
Re-enter SSN and DOB
Continue
Exit

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Based on the system look-up of the claimant's personnel data, some employee information will already be completed for you.
all appropriate information into each screen.

Use the TAB key to navigate between data fields, or use your mouse to click on the field you wish to add data into.

Emp. Data | Injury Desc. | Emp. Signature | Witness Statement | Supvsr Rpt

1. Name of employee

Last Name: PUBLIC First Name: JOHN

Middle Name: G Suffix: JR - JUNIOR

2. Social Security Number: 999-99-9999

3. Date of birth MM/DD/YYYY: 05-22-1964

4. Sex: (•) Male ( ) Female

5. Home Phone: 2025551212

6. Grade as of date of injury: Level: GS13 Step: 01

7. Employee's home mailing address

Street Address: 1600 PENNSYLVANIA AVENUE

City: WASHINGTON

State: DC ZIP Code: 20001

8. Dependents

- [ ] Wife, Husband
- [ ] Children under 18 years
- [ ] Other

Claim information

EDI claim number: 100000327 Status: SU

Trading partner ID: FECAEDI Status time: 05-28-2002 12:00:00 AM

Print Claim Cancel Exit

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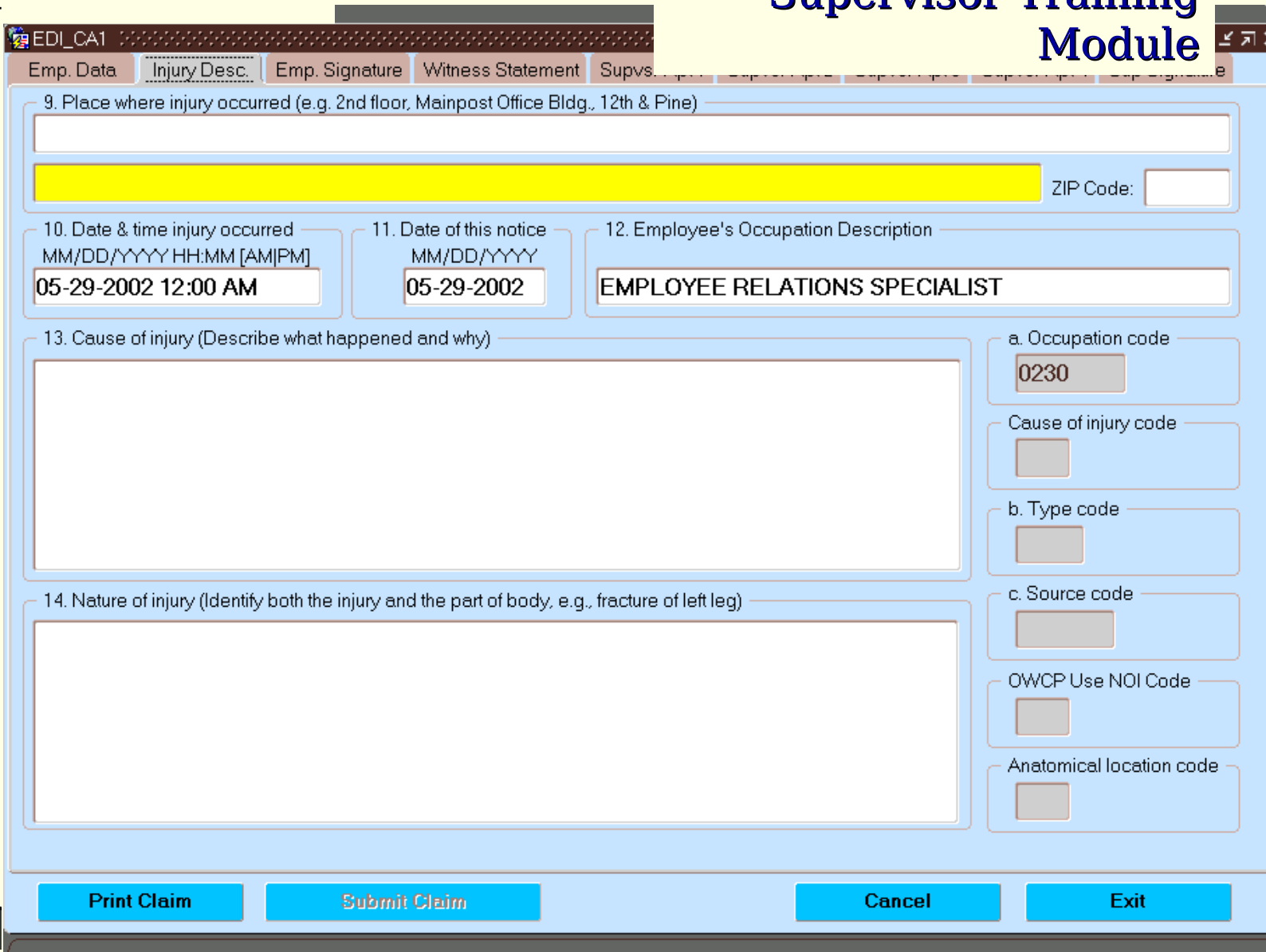
All date and time fields default to a time value of 12:00 a.m. You must overwrite this value with the actual time when the injury occurred.



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Item 15:
The employee must elect to receive continuation of pay or sick/annual leave. In the case where an employee is not eligible, or unavailable to make an election in Item 15, UNKNOWN must be checked.
section of the document is now complete. Click on "PRINT CLAIM" to print a hard copy for the employee to sign. A copy of this should be given to the employee, with the original going to the ICPA.

EDI_CA1

Emp. Data | Injury Desc. | Emp. Signature | Witness Statement | Supvsr Rpt 1 | Supvsr Rpt 2 | Supvsr Rpt 3 | Supvsr Rpt 4 | Sup Signature

15. I certify, under penalty of law, that the injury descibed above was sustained in performance of duty as an employee of the United States Government and that is was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

- ○ a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disablity for work continues beyond 45 days. If my claim is denied, I understand that the continuation of my regular pay shall be charged to sick or annual leave, or be deemed an overpayment within the meaning of 5 USC 5584.
- ○ b. Sick and/or Annual Leave
- ○ c. Unknown

I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its offical representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf _____ **Date** MM/DD/YYYY 05-29-2002

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provieded by the FECA or who knowingly accepts compensation to which tat person is not entitled is subject to civil or administratrive remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Print Claim | Submit Claim | Cancel | Exit

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As with the paper CA-1, the witness statement is optional. However, if a witness statement is entered, the remaining fields on this page (name, date

After entering witness data, print a copy and have the witness sign it. The signed paper copy should be forwarded to the ICPA.

EDI_CA1

Emp. Data | Injury Desc. | Emp. Signature | Witness Statement | Supvsr Rpt 1 | Supvsr Rpt 2 | Supvsr Rpt 3 | Supvsr Rpt 4 | Sup Signature

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Name of Witness: Last Name | First Name | Middle Name

Signature of witness: **Date signed:** MM/DD/YYYY

Street Address:

City:

State: ZIP Code:

Print Claim | Submit Claim | Cancel | Exit

Injury and Unemployment Compensation (ICUC) Division

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EDI_CA1

Emp. Data | Injury Desc. | Emp. Signature | Witness Statement | Supvs

17. Agency name and address of reporting office

Agency name:

Street Address:

City:

State: ZIP Code:

OWCP Agency Code

Charge Back CCPO

XR

OSHA Site Code

OWCP District Office #

18. Employee's duty station

Street Address:

City:

State: ZIP Code:

19. Employee's retirement coverage

CSRS FERS OTHER (identify)

20. Regular work hours

HH:MM [AM|PM] HH:MM [AM|PM]

From: To:

21. Regular work schedule

Sun. Mon. Tues. Wed. Thurs. Fri. Sat.

22. Date of injury

MM/DD/YYYY

05-29-2002

23. Date notice received

MM/DD/YYYY

05-29-2002

24. Date & time employee stopped work

MM/DD/YYYY HH:MM [AM|PM]

Print Claim | Submit Claim | Cancel | Exit

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EDI_CA1

Emp. Data | Injury Desc. | Emp. Signature | Witness Statement | Supvsr Rpt 1 | Supvsr Rpt 2 | Supvsr Rpt 3 | Supvsr Rpt 4 | Sup Signature

25. Date pay stopped
MM/DD/YYYY

26. Date 45 day period began
MM/DD/YYYY

27. Date & time employee returned to work
MM/DD/YYYY HH:MM [AM|PM]

28. Was employee injured in performance of duty?
(•) Yes ( ) No (If "No", explain)

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another?
( ) Yes (If "Yes", explain) (•) No

Print Claim | Submit Claim | Cancel | Exit

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EDI_CA1

Emp. Data | Injury Desc. | Emp. Signature | Witness Statement | Supvsr Rpt 1 | Supvsr Rpt 2 | Supvsr Rpt 3 | Supvsr Rpt 4 | Sup Signature

30. Was injury caused by third party?

- Yes
- No

(If "No", go to Item 32)

31. Name and address of third party (include city, state, and ZIP code)

3rd party name:

name continued:

Street Address:

City:

State: ZIP Code:

32. Name and address of physician first providing medical care (Include city, state, and ZIP code)

Last Name | First Name | Middle Name | Title

Street Address:

City:

State: ZIP Code:

33. First date medical care received *

MM/DD/YYYY

34. Do medical records show employee is disabled for work? *

- Yes
- No
- Unknown

Print Claim | Submit Claim | Cancel | Exit

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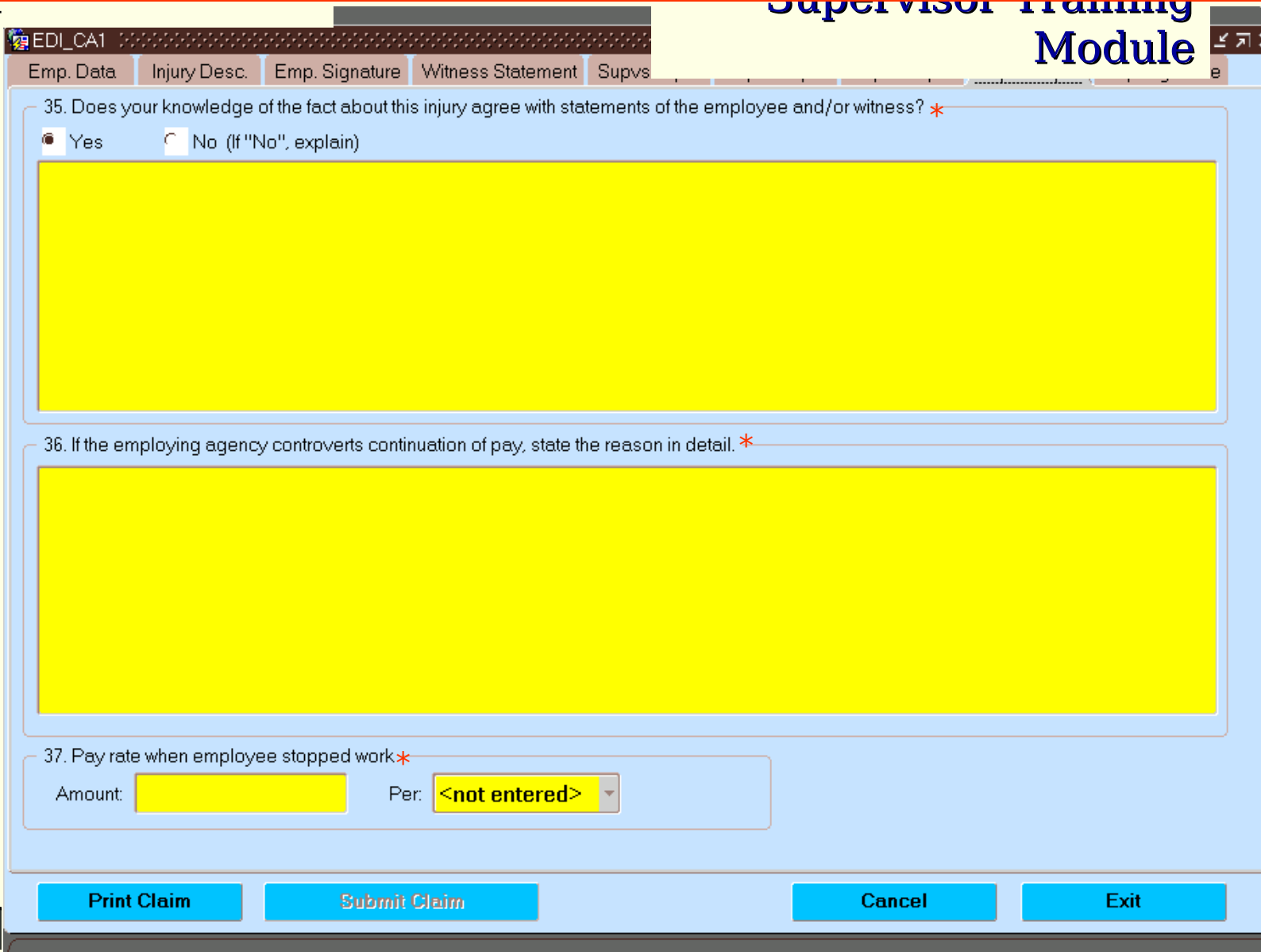
If the supervisor has a substantial disagreement about the facts surrounding the claimed injury, click “no” and provide an explanation.

controverting COP.



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Once all required fields have been entered, the supervisor must print a copy of the completed CA-1. This record must then be signed by the supervisor and forwarded the ICPA for filing.

EDI_CA1

Emp. Data | Injury Desc. | Emp. Signature | Witness Statement | Supvsr...

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception: *

Name of Supervisor: Last Name | First Name | Middle Name

* MM/DD/YYYY

Signature of supervisor: _____ **Date signed:** 05-29-2002

Supervisor's Title

Supervisor's Office phone number *

38. Filing Instructions *

- No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)
- No lost time, medical expenses incurred or expected: forward this form to OWCP
- Lost time covered by leave, LWOP, or COP: forward this form to OWCP
- First Aid Injury

Print Claim | Submit Claim | Cancel | Exit

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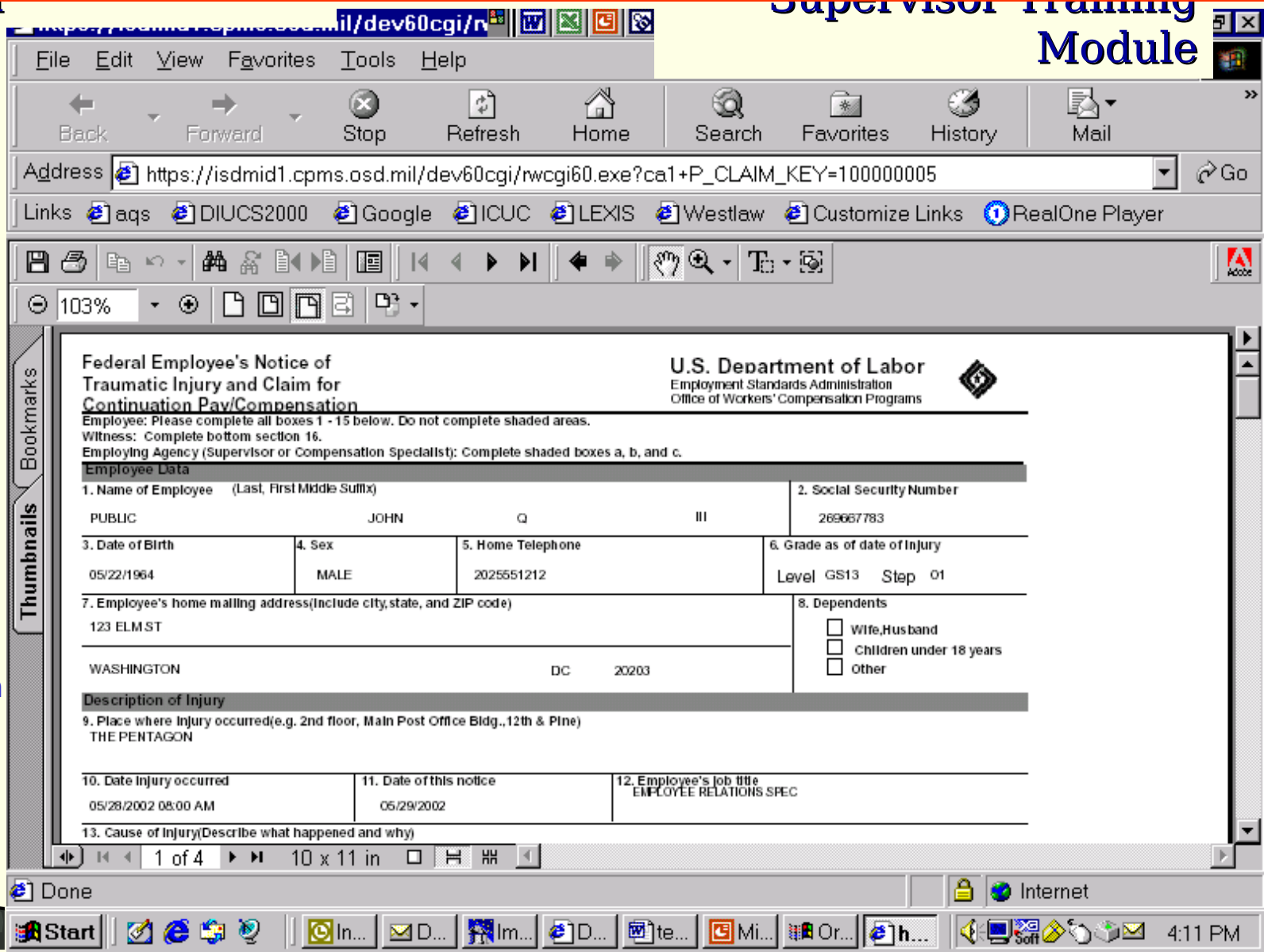
After clicking the “print” button, the system generates a Portable Document Format (PDF) file using the data you have entered. The information on this file must be verified, and printed if correct.

screen and use the File Tabs on the on-line claim screens to make the appropriate corrections.


File Edit View Favorites Tools Help
Back Forward Stop Refresh Home Search Favorites History Mail
Address https://isdmid1.cpms.osd.mil/dev60cgi/rwcgi60.exe?ca1+P_CLAIM_KEY=100000005
Links aqs DIUCS2000 Google ICUC LEXIS Westlaw Customize Links RealOne Player
103%
Bookmarks
Thumbnails
Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation
U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.
Employee Data
1. Name of Employee (Last, First Middle Suffix)
PUBLIC JOHN Q III
2. Social Security Number
269667783
3. Date of Birth
05/22/1964
4. Sex
MALE
5. Home Telephone
2025551212
6. Grade as of date of Injury
Level GS13 Step 01
7. Employee's home mailing address(Include city,state, and ZIP code)
123 ELM ST
WASHINGTON DC 20203
8. Dependents
Wife,Husband
Children under 18 years
Other
Description of Injury
9. Place where injury occurred(e.g. 2nd floor, Main Post Office Bldg.,12th & Pine)
THE PENTAGON
10. Date injury occurred
05/28/2002 08:00 AM
11. Date of this notice
05/29/2002
12. Employee's job title
EMPLOYEE RELATIONS SPEC
13. Cause of Injury(Describe what happened and why)
1 of 4
10 x 11 in
Done
Internet
Start
4:11 PM

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Now that the supervisor has printed a copy, the system will allow the claim to be transmitted. To transmit the record, click “submit claim.”

EDI_CAT

Emp. Data | Injury Desc. | Emp. Signature | Witness Statement | Supvsr Rpt 1 | Supvsr Rpt 2 | Supvsr Rpt 3 | Supvsr Rpt 4 | Sup Signature

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I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

	Last Name		First Name	Middle Name
Name of Supervisor:	SMITHSONG		SIMON	

Signature of supervisor: _____ **Date signed:** MM/DD/YYYY 05-29-2002

Supervisor's Title: HUMAN RESOURCES SPEC

Supervisor's Office phone number: 2025551212

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- ( ) First Aid Injury

Print Claim | Submit Claim * | Cancel | Exit

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Process Flow

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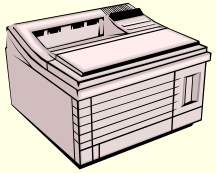

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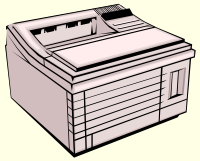

ICPA Prints claim. If Non-reportable, claim is REJECTED and form is placed in the OMF

Claim is batched for transmittal to OWCP

OWCP receives claim, validates data, and submits data to District OWCP for case number assignment

Claim Number is received at National OWCP and transmitted back to ICUC

Certain Claim data is then loaded into the DIUCS2000 system for case review.

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